



HCR INTAKE VERIFICATION UNIT

EOHHS / MassHealth
FAX Cover Sheet

Facility Information

Facility Name: _____

Sender's Phone No: _____

Sender's Name: _____

Head of Household (HOH) Information

Name: _____

DOB: _____

Soc. Sec. No: _____

Please include this cover sheet when faxing any documents to the EOHHS / MassHealth HCR Intake Verification Unit.

FAX NUMBER

617-241-3299

Place a checkmark (✓) in the appropriate space below identifying the attached verification(s).

_____ Income

_____ Immigration

_____ Citizenship and/or Identity (Required ONLY for applicants who claim to be a U.S. citizen/national)

_____ Other Health Insurance (other than Medicare)

_____ Other _____

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August 2008

